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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

PARAMOUNT HEALTH SYSTEMS, INC., personally and on behalf of the plaintiff class, and METROPOLITAN AMBULANCE ASSOCIATION,

Petitioners,

v.

ROBERT W. WRIGHT, as Director of the Illinois Department of Public Aid, and DONNA E. SHALALA, as Secretary of the United States Department of Health and Human Services,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

Of Counsel:

ROBERT W. McCANN
JAMES A. BARKER, JR.
GREEN, STEWART, FARBER & ANDERSON, P.C.
2600 Virginia Avenue, N.W.
Suite 1111
Washington, D.C. 20037
(202) 342-8700

BRUCE S. SPERLING
Counsel of Record
SPERLING, SLATER & SPITZ
55 West Monroe Street
Suite 330
Chicago, Illinois 60603
(312) 641-3200

(Additional counsel listed on inside front cover)

Midwest Law Printing Co., Chicago 60610, (312) 321-0220

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JUDITH S. SHERWIN
MARK J. BEREYSO
LEVENFELD, EISENBERG,
JANGER & GLASSBERG
33 West Monroe Street
Suite 2100
Chicago, Illinois 60603
(312) 346-8380

HARVEY J. BARNETT
HARVEY J. BARNETT
& ASSOCIATES, P.C.
200 West Adams Street
Suite 2220
Chicago, Illinois 60606
(312) 407-7300

Counsel for Petitioner,
Paramount Health Systems, Inc.

STEVEN A. KAUFMAN
PETER K. LEVITT
ROPES & GRAY
One International Place
Boston, MA 02110-2624
(617) 951-7000

DANIEL P. HOGAN
ROSS & HARDIES
150 North Michigan Avenue
Suite 2500
Chicago, Illinois 60601
(312) 750-8671

Counsel for Petitioner,
Metropolitan Ambulance
Association

QUESTIONS PRESENTED

1. Whether, in light of conflicting decisions of this Court, lower courts must defer to retroactive legislation purporting to clarify the intent of an earlier Congress, even though the circumstances of the later enactment indicate that Congress was not interpreting prior law, the affected statutes were enacted eleven years earlier, and the appellate courts, prior to the later enactment, had unanimously interpreted the affected statutes to the contrary.

2. Whether Congress, consistent with Article III of the Constitution, may apply a new statute to direct the outcome of litigation to which the government is a party, in order to benefit the government, where the statute has no other retroactive effect.

3. Whether the retroactive elimination of Medicare cost sharing payable by the government to health care providers, for items and services already rendered to QMBs, impairs vested property rights protected by the Due Process and Takings Clauses of the Fifth Amendment and, when applied to the States, the Contract Clause of Article I.

4. Whether, prior to passage of the Balanced Budget Act of 1997, federal law permitted the States to limit Medicare cost sharing incurred on behalf of QMBs.

PARTIES TO THE PROCEEDING

Petitioner, Paramount Health Systems, Inc., an Illinois corporation, individually and as a representative of a certified class of plaintiffs defined as "all entities and persons who have furnished items or services or will furnish items of services covered by Medicare Part B since March 1, 1993, to Illinois QMBs [qualified Medicare beneficiaries]," has no parent or subsidiary companies to be identified pursuant to S.C.R. 29.6.

Petitioner, Metropolitan Ambulance Association, is an Illinois not-for-profit corporation whose members are:

American Medical Response of Illinois, Inc., a Delaware corporation,

Consolidated Medical Transport, Inc., an Illinois corporation,

Superior Air Ground Ambulance Service, an Illinois corporation, and

Med Trans Ambulance, an Illinois corporation.

American Medical Response, Inc. is the parent corporation of American Medical Response of Illinois, and Laidlaw Medical Transportation, Inc. is the parent corporation of Med Trans Ambulance. All the shares of Laidlaw Medical Transportation, Inc. are held by Laidlaw, Inc.

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PETITION FOR WRIT OF CERTIORARI

Petitioners, Paramount Health Systems, Inc. and Metropolitan Ambulance Association, respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit dated March 19, 1998.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at *Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706 (CA7 1998) and is reprinted in the Appendix. App. 1. The opinion and judgment of the district court granting summary judgment in favor of Petitioners are not reported but are reprinted in the Appendix. App. 13. An earlier opinion of the district court denying Respondents' motions to dismiss is published at *Paramount Health Systems, Inc. v. Wright*, 907 F.Supp. 1212 (N.D. Ill. 1995).

JURISDICTION

The judgment of the Court of Appeals was entered on March 19, 1998, and this Petition for Writ of Certiorari was timely filed. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This case concerns the interpretation of 42 U.S.C. §§ 1396a(a), 1396a(n), and 1396d(p), before and after enactment of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, and the related provisions of 42 U.S.C. §§ 1395*l*(a), 1395u(h)(l), 1395w-4(a), 1395cc(a)(2)(A), 1396b(b) and 1396c, all of which are set forth in the Appendix. This case also concerns issues arising under Article I, § 10, Article III, § 1 and Amendment V of the United States Constitution, which provisions are set forth in the Appendix.

STATEMENT OF THE CASE[1]

Petitioner, Paramount Health Systems, Inc. (Paramount) filed this class action[2] in March 1995 in the United States District Court for the Northern District of Illinois, against the Director of the Illinois Department of Public Aid (the Director) and the Secretary of the United States Department of Health and Human Services (the Secretary). Paramount alleged the Director, with the knowledge and approval of the Secretary, illegally refused to pay Medicare cost sharing, as required by federal law, on behalf of low-income patients enrolled in Medicare Part B, known as "qualified Medicare beneficiaries" or "QMBs" or "quimbies." Petitioner Metropolitan Ambulance Association (Metropolitan) was granted leave to intervene in the district court action. Jurisdiction in the district court was invoked under 28 U.S.C. §§ 1331, 1343, and 1361.

The district court granted summary judgment in favor of Petitioners and enjoined Respondents' continued violation of federal law, but stayed its injunction pending a timely appeal to the Court of Appeals for the Seventh Circuit. App. 24-25, 28.

While the appeal was pending in the Seventh Circuit, Congress enacted the Balanced Budget Act of 1997 (BBA) which contained a provision (Section 4714) purporting to "clarify" the law by adding numerous statutory provisions eliminating prospectively any right of Medicare Part B

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[1] The issues and essential facts involved in this petition are the same as contained in the petition for writ of certiorari submitted in the case of *Gilmore v. Shalala*, docket no. 97-1949 (herein "Gilmore") filed June 1, 1998.

[2] In its final judgment, the district court certified a class of plaintiffs defined as "all entities and persons who have furnished items or services or will furnish items or services covered by Medicare Part B since March 1, 1993 to Illinois QMBs." (App. 25). Class certification was not challenged by Respondents in the Court of Appeals.

providers to payment of Medicare cost sharing, including deductibles and the 20 percent co-payments, for items and services rendered to QMBs. Section 4714 also purported to apply the "clarification" retroactively to pending litigation, with respect to items and services already rendered. App. 39-41.

The Seventh Circuit, after supplemental argument and considering the effect of Section 4714 of the BBA, reversed the district court. Finding itself in a "quandary" in light of conflicting Supreme Court precedent, and pending further clarification as to the weight to be accorded the views of a subsequent Congress in determining the intent of an earlier one, the court felt "constrained" to give the BBA *some* weight in interpreting the QMB provisions, which, in the court's view, was sufficient to create an ambiguity and "tip the balance in favor of *Chevron* deference." App. 10-11.

A. QMBs and Medicare Cost Sharing

This case involves the weight, if any, to be accorded Congress' 1997 "clarification" of statutes which four circuit courts of appeals held to unambiguously require the federal and state governments to pay Medicare cost sharing incurred on behalf of QMBs, and whether the application of a "clarification" which eliminates the government's cost sharing obligations for items and services rendered before the enactment is unconstitutional.

All QMBs are eligible for coverage under both parts of Medicare, the federal health insurance program for the elderly and disabled. Part A of Medicare automatically covers hospital and other institutional care for most Social Security beneficiaries. *See* 42 U.S.C. §§ 426(a), 1395c to 1395i-4. Medicare Part B, a supplemental program, requires that an eligible person enroll and pay a premium (much like a commercial insurance plan). *See id.*, §§ 1395o-1395s. Part B covers services of physicians and other health professionals, as well as those of ambulance, home

care, and medical equipment suppliers. *Id.*, §§ 1395j-1395w-4j.

Medicare Part B pays 80 percent of the "reasonable charge" for most covered services. The beneficiary is responsible, in the ordinary case, for paying 20 percent of the charge—the "cost sharing" or coinsurance. *Id.*, §§ 1395*l*, 1395cc(a)(2)(A), 1395m, 1395u(b)(3) and (h); 42 C.F.R. §§ 424.55, 400.202. App. 30-31, 44-45. The "reasonable charge" for physician services, and other covered services, is based on an annual fee schedule set by the Secretary. 42 U.S.C. § 1395w-4.

Medicaid, the other relevant program, pays for medical assistance for the poor of any age. The federal and participating state governments (all 50, during the relevant time) jointly fund and administer Medicaid. *See id.* §§ 1396b, 1396d(b).

Each participating state enters into an agreement with the Secretary and must implement a "State Plan" which meets federal statutory and regulatory requirements as to, among other things, the individuals and services to be covered and the amount that providers will be paid for services. *Id.*, §§ 1396a, 1396b. *See Harris v. McRae*, 448 U.S. 297, 301 (1980). Most states adopt a fee schedule or otherwise set rates for the amounts to be paid physicians and other providers. *See* 42 U.S.C. § 1396a(a)(30). The federal government oversees the states' administration of the program and compliance with federal law, *id.*, § 1396c, and reimburses each state for at least one-half of the costs it incurs. *See generally id.*, §§ 1396b, 1396d(b).

The first statute at issue in this case required that an approved state Medicaid plan cover the Medicare "cost sharing" of QMBs. 42 U.S.C. § 1396a(a)(10)(E). App. 33-34. The QMB population includes two categories of low-income elderly and disabled: (1) a group of Medicare beneficiaries who are poor enough to qualify for full Medicaid benefits ("dual eligibles"), and (2) a second group, also Medicare

beneficiaries, whose income is too high for Medicaid but otherwise falls below a statutory low-income standard ("pure QMBs"). *See* 42 U.S.C. §§ 1396d(p)(1) (App. 37); *Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886, 889 (CA3 1994). The second population, so-called pure QMBs, is not eligible for Medicaid, though Medicaid is designated by statute to cover Medicare cost sharing. *See* 42 U.S.C. § 1396a(a)(10)(E)(VIII) (App. 34). In 1988, Congress made state coverage of cost sharing for both categories of QMBs mandatory. *See* Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 683, 748 (1988); *see* H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess. 59-60 (1988).

The second key statute set out the elements of Medicare "cost sharing" of QMBs to be covered under a state Medicaid plan, including, as relevant here: (i) Medicare Part B premiums; (ii) annual deductibles for Part B; and (iii) coinsurance under Part B. 42 U.S.C. § 1396d(p)(3). App. 38. States were required to cover these costs regardless of whether the same services would be covered under the state's Medicaid plan. *Id.*, § 1396d(p).[3]

In 1986, Congress enacted 42 U.S.C. § 1396a(n) simultaneously with 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p). Prior to its amendment in 1997 as part of the BBA, Section 1396a(n) stated that a state "may" exceed its Medicaid rates in paying Medicare cost sharing amounts on behalf of QMBs. *See id.* (West 1997 Supp.); App. 34. The dispute here arose from the Secretary's attempt to create an

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[3] The statutory specification of the obligation to cover Part B coinsurance is stated in terms of a specific formula. The costs to be covered are defined as "[t]he difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'." 42 U.S.C. § 1396d(p)(3)(D). Section 1395*l*(a) of the Medicare Act states, with respect to physician services covered by Part B, that Medicare will pay 80 percent of the Medicare-approved fee schedule amount.

ambiguity among §§ 1396a(a)(10)(E), 1396d(p)(3) and 1396a(n).

After enactment of the three statutes, the Secretary permitted states to limit—and, in almost all cases, to refuse to pay—Medicare cost sharing for QMBs. The federal government took the position that states were not required to pay the 20 percent Part B coinsurance on behalf of QMBs to the extent that the amount paid by Medicare (i.e., 80 percent of the Medicare rate) exceeded the amount that the state Medicaid program would pay for the same service. Illinois adopted such a limitation as part of its Medicaid Plan and by way of an administrative regulation. 89 Ill. Adm. Code § 140.21. App. 45.

The policy allowed Illinois, and several other states, to virtually eliminate payment of Medicare cost sharing for items and services rendered to QMBs.[4] In almost all cases,

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[4] States where providers' claims for payment in full of Medicare cost-sharing were pending as of August 1997 (passage of the BBA), in addition to Illinois and California (see *Gilmore*), include: Florida (*Savona v. Cook*, pending in the United States District Court for the Northern District of Florida, Case No. 4:96 CV41-WS, and *Agency for Health Care Administration v. Savona*, pending in the District Court of Appeal, First District, Case No. 97-1496; Class certified consisting of all physicians who have furnished Medicare Part B services to Florida QMBs); Wisconsin (*Kulkarni v. Leean*, pending in the United States District Court, West District of Wisconsin, Case No. 96-C-884-S; Class certified consisting of all health care providers of Medicare Part B items and services); Michigan (*Cardiology Associates v. Haveman*, pending in the State Court of Claims, 30th Circuit Court for the State of Michigan, Case No. 96-16517-CM); Tennessee (*Stohler v. Wadley*, pending in the Claims Commission of the State of Tennessee, Eastern Division, Claim No. 97002700); New Jersey (*Blecker v. State of New Jersey*, pending in the Appellate Court of New Jersey, Docket No. 5377-97-T-5); Massachusetts (*Briggs v. Commonwealth of Massachusetts*, pending in the Appellate Court of Massachusetts. *See* also *McCreary v. Offner*, 1998 U.S. Dist. LEXIS 4462 (D.D.C. Mar. 31, 1998) addressing the same facts and issues for the District of Columbia.

Illinois' Medicaid payment rates were lower than the 80 percent federal share of a Medicare Part B payment. *See* App. 50. Under the policy, physicians and suppliers in Illinois received nothing for part B coinsurance on behalf of QMBs, and were paid only 80 percent of the Medicare rate for services provided to these Medicare beneficiaries. The Secretary concurred in and approved the Director's policy of non-payment of cost sharing incurred on behalf of QMBs.

B. Prior Litigation

Medicare providers in other states (which had adopted the same limitation on payment of QMB cost sharing) sued the Secretary and applicable state officials and prevailed in all four cases to reach the courts of appeals. In each instance, the court of appeals held that 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p)(3) clearly required states to pay the full 20 percent Medicare coinsurance on behalf of QMBs and that the Secretary lacked authority to permit the states to cap those payments at a Medicaid fee schedule amount. *See New York City Health and Hosp. Corp. v. Perales*, 954 F.2d 854, 858-63 (CA2 1992); *Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886, 892-97 (CA3 1994); *Haynes Ambulance Service v. Alabama*, 36 F.3d 1074, 1076-77 (CA11 1994); *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444, 1450-60 (CA4 1994) (collectively "the four Circuits").

The Secretary argued in the four Circuits that 42 U.S.C. § 1396a(n), by negative implication, authorized the states to pay less than the Medicare rates for services to QMBs. In particular, the Secretary contended that because the statute provided that the States "may" exceed Medicaid rates when paying Medicare cost sharing on behalf of QMBs, states may choose not exceed those rates, and in fact pay nothing at all, if the federal government's reimbursement already exceeded the Medicaid rates. The Secretary asserted that this interpretation was entitled to

deference under *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *See e.g., Kozlowski*, 42 F.3d at 1450; *Snider*, 29 F.3d at 902-03; *Perales*, 954 F.2d at 858, 861-62.

The four Circuits each concluded, however, that sections 1396a(a)(10)(E) and 1396d(p)(3) were clear and contradicted the Secretary's interpretation, and that, therefore, *Chevron* deference was inappropriate. *See Perales*, 954 F.2d at 858-62; *Snider*, 29 F.3d at 892-97, 902-03; *Kozlowski*, 42 F.3d at 1450-60; *Haynes Ambulance*, 36 F.3d at 1076-77 (adopting and expanding upon the *Snider* analysis).

Three of the four Circuits concluded that 42 U.S.C. § 1396a(n) was better understood as an exception to the Medicaid Act's requirements in 42 U.S.C. §§ 1396b(a)(1) and 1396a that states not exceed payment schedules or methods otherwise approved in a State Plan. *See Haynes*, 36 F.3d at 1076-77 (incorporating *Snider*'s reasoning); *Snider*, 29 F.3d at 894-96; *Perales*, 954 F.2d at 859-60. This view recognized that when States pay the Part B coinsurance on behalf of QMBs, providers receive 100 percent of the Medicare-approved rate—which in most cases is more than the Medicaid rate for the same service. But for § 1396a(n), such payments would violate the Medicaid State Plan requirements. *See id.*

C. Trial Court Proceedings

The district court found that the Medicare and Medicaid Acts unequivocally required the State of Illinois to directly pay Medicare cost sharing for items and services furnished to QMBs, as defined under federal law, including the amounts defined at 42 U.S.C. § 1396d(p)(3). The Illinois Medicaid plan and the regulations and contracts which interpreted and applied the state's cost sharing obligation were declared invalid and unenforceable to the extent they limited such cost sharing reimbursement to amounts or

rates less than the full amount of Medicare cost sharing as defined, or to the extent they required persons and entities who furnished items or services covered by Medicare Part B to enter into "provider agreements" with the Illinois Department of Public Aid (IDPA), which in turn required such persons and entities to seek payment from third parties or otherwise limited the amount of reimbursement for Medicare Part B items and services furnished to QMBs residing in nursing homes. The district court enjoined Respondents from continuing to limit state cost sharing for services rendered to QMBs, but stayed enforcement of that injunction pending Respondents' timely appeal to the United States Court of Appeals for the Seventh Circuit. App. 24-25, 28.

D. The Balanced Budget Act of 1997

While the appeal by Respondents was pending in the United States Court of Appeals for the Seventh Circuit, the President signed the Balanced Budget Act of 1997 ("BBA"), Pub. L. 105-33, 111 Stat. 251 et seq. in August of last year. Section 4714 of the BBA added numerous new statutory provisions which authorized the states to limit Medicare cost sharing payments for QMBs based on Medicaid rate schedules and, further, prohibited physicians and suppliers from billing individual QMBs to the extent that a state did not pay the full Medicare cost sharing amount. *See* App. 39-41. Section 4714 also added a "savings" provision to Section 1396a(n), which preserved the rights of physicians and suppliers to collect cost sharing amounts in such cases from commercial insurers in the event an individual QMB might be able to afford a private Medicare supplemental insurance policy. App. 40.

The caption to Section 4714 ("Clarification Regarding State Liability for Medicare Cost-Sharing") and the accompanying Conference Report indicated that Congress purported to enact a "clarification" of the law, which the four Circuits had interpreted to the contrary. *See* H. Conf.

Rep. 105-217, 105th Cong., 1st Sess. (July 30, 1997) at 870-71.

Congress made Section 4714 effective prospectively to QMB cost sharing payments made on and after the date of enactment (August 5, 1997), and, retrospectively, to a state's payment for "items and services furnished before" enactment "if such payment is the subject of a law suit that is based on" 42 U.S.C. §§ 1396a(n) and 1396d(p) and "is pending as of, or is initiated after, the date of enactment of this Act." App. 41. The BBA thereby made Section 4714 applicable to the government's obligation to pay for items and services already provided if payment for those services had been or would be sought through the courts.

E. The Court of Appeals Decision

The Seventh Circuit reversed and remanded. In contrast to the Ninth Circuit in *Gilmore*, which gave total deference to Congress' "clarification" label, the Seventh Circuit viewed the issues and underlying policies differently. While acknowledging that the language in *Loving v. United States*, 517 U.S. 748, 770 (1996) requires that a subsequent Congressional clarification be given "great weight," the Seventh Circuit noted that a separate and contrary line of Supreme Court decisions holds that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." App. 8-9, *citing United States v. Philadelphia National Bank*, 374 U.S. 321 (1963) and *South Dakota v. Yankton Sioux Tribe*, 118 S.Ct. 789 (1998).

The Seventh Circuit could not reconcile the competing lines of authority, *i.e.*, "the *Loving* line" and "the *Philadelphia National Bank* line," and concluded its analysis by stating:

> So we're in a quandary concerning the continued vitality of the *Loving* line, and would welcome clarifi-

> cation from the Supreme Court—pending which we feel constrained by *Loving* to give *some* weight to Congress' [subsequent] declaration in the Balanced Budget Act [which purported to "clarify" the meaning of prior federal statutes involving Medicare and Medicaid].

App. 10.

Chief Judge Posner, writing for the Seventh Circuit, further explained why the court believed the issue needed to be addressed by this Court and why the *Philadelphia National Bank* line of cases seemed to be premised on sounder policy considerations than the *Loving* line. In particular, Chief Judge Posner wrote:

1. The "great weight" standard of *Loving* cannot easily be reconciled with the principle that Congress cannot direct the outcome of a pending case without changing the law applicable to that case. Otherwise, "a disappointed litigant in a statutory case in a federal district court could [as in the present case] scurry to Congress while the case was on appeal and request a 'clarifying' amendment that would reverse the interpretation that the district judge had given to the statute, even if that meaning was crystal clear . . . ." App. 9.

2. A subsequent Congress has little insight into the meaning of a Congress that sat eleven years earlier. "The membership of Congress had largely turned over during the interim and surely few members of the 105th Congress remembered what the membership's intentions had been regarding the esoteric issue of the reimbursement rate for providers of medical services to quimbies." App. 8. As Chief Judge Posner observed, "[t]here is an air of unreality" in treating a subsequent Congressional act as actually clarifying the original meaning of an earlier Congress. App. 8.

3. In addition, a subsequent Congress (or any Congress) is not intended by the Constitution or the electorate to be an interpretive body, and is not bound by duty or perspec-

tive to maintain the continuity or predictability of the law. "Congress is not an interpretive body and has no felt duty to maintain continuity with the past." App. 8.

4. Still further, a sitting Congress is, of necessity, concerned with political, pragmatic issues, such as budgets, and not in interpreting the law. As the Seventh Circuit observed:

> The location of the 1997 amendments in a statute labeled the "Balanced Budget Act" and concerned primarily with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the 1997 quimby provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government. Nothing in the provisions themselves suggests a process of interpretation; they merely declare that the states are not required to reimburse quimby providers at the Medicare rate.

App. 9.

Accordingly, while acknowledging that Paramount had "the better interpretation," the court felt constrained to follow *Loving*—at the same time, welcoming clarification from this Court.

SUMMARY

This case presents several bases for granting a writ of certiorari: (a) resolution of a conflict among this Court's prior decisions concerning the weight to be accorded subsequent legislation declaring the meaning of a prior statute, (b) resolution of the conflict among the circuits regarding the meaning of the prior law governing payment of cost sharing incurred on behalf of QMBs, (c) resolution of the Separation of Powers issues raised by the scope of the retroactive legislation which benefits the federal government in pending litigation, and (d) resolution of the constitutional issues arising from the government's retroactive

elimination of its own cost sharing obligations with respect to items and services already rendered.

Certiorari should be granted to resolve conflicting decisions of this Court concerning the weight, if any, to be given legislative pronouncements purporting to clarify prior law. The conflict between the *Loving* line and the *Philadelphia National Bank* line leaves the appellate courts "in a quandary," and the *Loving* line encourages disappointed litigants—and particularly the Government—"to scurry to Congress" whenever a district judge interprets a federal statute to require greater payments from the Federal Treasury than the supervising agency—and the then-sitting Congress—would prefer. App. 9-10.

Of equal importance is the abdication by the appellate courts of their judicial function and their willingness to allow the government, as the disappointed litigant, to "scurry to Congress" for a "clarification" of a law enacted eleven years earlier which the courts had held to be clear. Specifically, this Court should grant certiorari to explain the significance of *United States v. Klein*, 13 Wall (80 U.S.) 128 (1872), to selective, retroactive enactments such as Section 4714. Specifically, the Court should resolve whether, under *Klein*, retroactive legislation, which affects only pending lawsuits and effectively directs the outcome in favor of the federal government as a party to them, is an invalid usurpation of the Article III role of the judiciary to interpret the law.

Further, this Court should resolve the conflict that now exists among six courts of appeal concerning the proper interpretation of the QMB law as it existed prior to the BBA—a conflict that exists solely as a consequence of a congressional "clarification," enacted eleven years later. The conflict presents a threat, not only to the future integrity of the Medicare program, but to the integrity of all federal procurement programs. Petitioners acknowledge that Congress may change the law, and in so doing change the prospective expectations of those who contract with the

federal government. The court of appeals in this case, however, ceded to Congress a power to retroactively change the rules governing payment for items and services already rendered.

Such deference to Congress inappropriately elevates one line of the Court's decisions (the *Loving* line) over another (the *Philadelphia National Bank* line) and permits Congress to trample the concepts of separation of powers, substantive due process, non-impairment of contracts, and just compensation, all in the interest of budgetary convenience. Moreover, the practical effect of Congress' action renders the government a particularly "[un]reliable contracting partner," contrary to this Court's admonition in *United States v. Winstar Corp.*, 518 U.S. 839, 116 S.Ct. 2432, 2459 (1996), that the United States lacks power to repudiate its own debts simply to save money. *See id.*, 116 S.Ct. at 2459-60 & n.28, 2464-65 & n.39, 2468-59 n.51 (plurality opinion); *id.* at 2473, 2475-76 (Breyer, J., concurring); *id.* at 2478-79 (Scalia, J., concurring).

REASONS FOR GRANTING THE PETITION

I. The Decision Below and a Recent Decision of the Ninth Circuit Highlight the Need to Resolve The Conflicting Standards for Judicial Deference to the Legislative Branch.

A. The Purported "Clarification" Unconstitutionally Displaced the Circuit Courts' Unanimous Interpretation of Prior Law and Created a Conflict Among the Circuits.

Section 4714 of the BBA purports, retroactively, to "clarify" statutes that four circuit courts of appeals found to have a clear meaning to the contrary. The Second, Third, Fourth, and Eleventh Circuits unanimously rejected the Secretary's interpretation and held that the plaintiffs, all

situated identically to the Petitioners, were entitled to full payment for services rendered to QMBs at the statutorily defined Medicare rates. Through Section 4714, Congress plainly acted to deprive the Petitioners and similarly situated litigants of an objective, judicial interpretation of their statutory rights. The statutes at issue are complex, but as the Second Circuit recognized:

> [C]omplexity is not the same as ambiguity. Congress passes legislation with specific purposes in mind. When the ordinary tools of statutory construction permit us to do so, we must attempt to discover those purposes from the text, structure and history of the acts in question.

Perales, 954 F.2d at 862-63. *See* also *Snider*, 29 F.3d at 902 ("the statutory language, context and legislative history demonstrate that Congress has spoken on the issue").

The four Circuits ascertained the meaning of the original 1986 statute from its text, structure and history. All four Circuits found a plain meaning interpretation of the statute sufficient to make inapplicable any deference to the Secretary's contrary interpretation. *See Snider*, 29 F.3d at 902 ("Our analysis reflects that although interpreting the relevant statutory provisions is not a simple task, there is in fact no ambiguity as to how much states have to pay. . . . Accordingly, *Chevron* has no application"); *Perales*, 954 F.2d at 862-3 ("[W]here we confront a statute that evinces a legislative purpose clearly at odds with the proffered administrative interpretation, we should not defer"); *Kozlowski*, 42 F.3d at 1459 ("[T]here can be no doubt but that the QMB is a Medicare enrollee, and that payment on her behalf must be made at the Medicare rate"); *Haynes*, 36 F.3d at 1076 ("the statute unambiguously requires the state to pay the full amounts specified . . .").

The Seventh and Ninth Circuits found, however, that the four Circuits' interpretation of the law may be upset by an

intervening "clarification" from Congress. Both the Seventh and Ninth Circuits felt constrained to defer to the Congressional clarification due to a line of this Court's decisions, represented by *Loving*, directing that subsequent legislation be given "great weight" in interpreting prior law. *See* App. 10; *Beverly Comm. Hosp. Ass'n v. Belshe*, 132 F.3d 1259, 1265-66 (CA9 1997). The Seventh and Ninth Circuits deferred to the congressional "clarification" without even analyzing the prior law or the reasonableness or consistency of the Secretary's interpretation of that law. App. 10-11.[5]

But the *Loving* line of analysis conflicts, in these circumstances, with another line of cases, defined by *Philadelphia*

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[5] The Seventh Circuit questioned the prevailing view of the purpose of Section 1396a(n), if the statute were read to clearly mandate reimbursement at Medicare rates (which it does), and given that providers had, for twenty years, been receiving reimbursement at Medicare rates, without the spectre of penalties for exceeding Medicaid limits. The point, however, failed to consider the fact that the 1986 QMB provisions extended, for the first time, Medicaid benefits to persons who were not otherwise eligible for Medicaid. The court's further concern that Congress may have required states to treat pure QMBs more favorably than dual eligibles (who were more needy) was also misplaced. Congress had always allowed states to impose a portion of their cost-sharing obligations on dual eligibles under former § 1396a(a)(15). Commencing in 1986, with the QMB provisions, Congress enacted § 1396o, which similarly allowed states to impose a nominal charge on QMBs. When Congress repealed § 1396a(a)(15), and rolled dual eligibles into QMBs, it retained § 1396o, thereby allowing states an option of imposing a nominal charge on both types of QMBs. In neither case, however, did Congress establish an option to pay providers less than the full amount of Medicare cost-sharing. Finally, both circuit courts failed to consider contemporaneous legislative history, cited in *Snider*, 29 F.3d 886, 895 (CA3 1994), which, when discussing Section 1396a(n), emphasized a comparison between the Medicare and Medicaid rates of payment, rather than the discretion of the states to cap Medicare cost-sharing. *Id.*, citing H.R. Conference Report No. 99-1012, 99th Cong. 2d Sess. 395-96 (1986), reprinted in 1986 U.S.C.C.A.N. 3869, 4040-41.

National Bank, holding that "[t]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *See* 374 U.S. at 348-49. The Seventh Circuit found itself in a "quandary" when confronted with these conflicting precedents and accordingly invited this Court's clarification.

B. The Objective Circumstances of the Enactment Are At Odds With the Deference Given to That Statute by the Court of Appeals.

The language and architecture of Section 4714 reflect a wholesale change in the law, including the creation of numerous substantive provisions which were lacking in the prior law.

The Seventh Circuit recognized the logical difficulty with accepting Section 4714 as a "clarification" of prior law. As Chief Judge Posner observed, Congress likely was not "interpreting" prior law when it passed its "clarification," but more likely was overturning judicial interpretation of the law to create budgetary savings. "It is far more realistic to regard the 1997 [QMB] provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government." App. 9.

Section 4714 did not modify or elucidate the language of the original § 1396a(n) to provide the "cap" the Secretary argued was always contained within it. To the contrary, Section 4714 added a completely new provision to achieve that result. The new provision, designated 42 U.S.C. § 1396a(n)(2), provides that the states may now limit their co-payments for QMBs by capping physician payments at the lower state Medicaid fee schedules. App. 39. Congress kept the original provision intact, re-numbered as 1396a(n)(1). *Id.* The old Section 1396a(n) must, therefore, serve the purpose it always served, i.e., to make clear that the states

would not violate their own Medicaid plans when making QMB payments at the higher Medicare rate, as explained in *Snider*. *See* 29 F.3d at 895.

Section 4714 further created two additional provisions. First, in authorizing the states to pay less than the full Medicare cost sharing amounts, Section 4714 added—for the first time—provisions (designated as §§ 1396a(n)(3)(A) and (B)) which specifically state that the total of whatever payment is now made by the state (even if zero), plus the payment from Medicare (i.e., 80 percent of the Medicare rate), "shall be considered to be payment-in-full for the service" and that "the beneficiary [i.e., the QMB] shall not have any legal liability to a provider" for any unpaid amounts. App. 40. These new provisions could only have been necessary to insulate QMBs against financial exposure otherwise created by the principal changes in the law (i.e., § 1396a(n)(2)), which, by authorizing the states to pay less than the full Medicare cost sharing amount, would have relegated Part B providers to seek cost sharing from the QMBs themselves.

Viewed logically, the enacting Congress originally did not hold QMBs harmless for cost sharing because Congress envisioned that the states would fulfill their obligations to pay the cost sharing in full, leaving no exposure for the QMBs. In other words, the original statute did not specifically address this problem because Congress did not believe it had created a problem.

The new subsection 1396a(n)(3) also provides that its terms are not intended to prevent full payment for QMBs at the higher Medicare rate if the co-payments can be obtained from some other third-party source such as "a Medicare supplemental policy or an employer retiree health plan." App. 40. This provision, likewise, was necessary only because Section 4714 gave the states a *new* option to "cap" their Medicare cost sharing payments at

the lower Medicaid scheduled amounts.[6]

Standing alone, nothing in the language or construction of the amendments made by Section 4714 indicates that its purpose is anything other than a change in the law. Rather, the purported purpose of "interpreting" the statute originally enacted in 1986 is discernable only from the caption attached to the uncodified statute and the accompanying legislative history.

C. This Court's Guidance Is Required to Clarify the Bounds of Judicial Deference in These Circumstances.

The four Circuits held against the interpretation urged by the Director and the Secretary. It was only *after* Section 4714 that two circuits held to the contrary, in reliance on the *Loving* line of cases.

The Seventh Circuit followed *Loving* reluctantly, noting that

> [W]e're in a quandary concerning the vitality of the *Loving* line, and would welcome clarification from the Supreme Court—pending which we feel constrained by Loving to give *some* weight to Congress' declaration in the Balanced Budget Act. . . . [I]t is enough to tip the balance in favor of [the government's proffered interpretation] . . . *while it seems to us that Paramount has the better interpretation* . . . .

App. 10-11 (first emphasis in original; second emphasis added).

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[6] Finally, even the drafters of Section 4714 did not have confidence in the "clarification" pretext—the new law was given both an "effective" date and a "retroactive" application. App. 41. A true "clarification" requires neither, because it merely elucidates the always-present meaning of the original statute.

This Court has stated: "We have observed on more than one occasion that the interpretation given by one Congress (or a committee or a Member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute." *Public Employees Ret. System v. Betts*, 492 U.S. 158, 168 (1989). A later statute may, depending on the circumstances, have "little, *if any*, significance" in interpretation of the earlier enactment. *See Rainwater v. United States*, 356 U.S. 590, 593 (1958) (disregarding later statute) (emphasis added); *see also South Dakota v. Yankton Sioux Tribe*, 118 S. Ct. 789, 803 (1998) (same); *Gwaltney of Smithfield, Ltd. v. Chesapeake Bay Fdn., Inc.*, 484 U.S. 49, 63 n.4 (1987) (same); *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 839-40 (1988) (same).

In contrast to the Ninth Circuit, the Seventh Circuit suggested that the reasoning of *Philadelphia National Bank* may be more appropriate in circumstances like those of the present case, where Congress' subsequent declaration of its predecessors' intent serves a wholly distinct budgetary purpose. App. 8-9. Congress plainly sought to enhance the expected savings in future years by labeling the change in law a "clarification" and directing the result in cases interpreting the prior law. App. 9. Victory in pending cases would necessarily avoid payment of Medicaid matching funds from the federal purse.

Certiorari should be granted to resolve the conflict presented by the *Loving* line and *Philadelphia National Bank* line of cases and resolve the "quandary" identified by the Seventh Circuit. *See S.E.C. v. United Benefit Life Ins.*, 387 U.S. 202, 207 (1967) (Supreme Court may grant certiorari to resolve inconsistencies in its own decisions).

II. The Court of Appeals Improperly Elevated Deference to Congressional "Clarification" Above This Court's Long-Standing Separation of Powers Doctrine.

While courts are to apply the law in effect at the time of decision, *see United States v. The Schooner Peggy*, 1 Cranch (5 U.S.) 103, 110 (1801), the retroactive provision of Section 4714 presents a more serious and fundamental question as to whether the enactment was an impermissible intrusion into the judicial function. Declaring the meaning of an existing statute is unquestionably a judicial, not a legislative, function. *Pierce v. Underwood*, 487 U.S. 552, 566 (1988) ("it is the function of the courts and not the Legislature . . . to say what an enacted statute means"); *Marbury v. Madison*, 5 U.S. 137 (1803).

In *United States v. Klein*, 13 Wall. (80 U.S.) 128 (1872), this Court made clear that Congress may not prescribe a new rule of decision in pending cases to benefit the United States. As this Court has since noted, "of obvious importance to the *Klein* holding was the fact that Congress was attempting to decide the controversy at issue in the Government's own favor." *United States v. Sioux Nation*, 448 U.S. 371, 405 (1980). "[E]ven more important, the proviso at issue in *Klein* had attempted 'to prescribe a rule for the decision of a cause in a particular way.'" *Id.* (quoting *Klein*, 13 Wall. at 146).

The meaning of *Klein* has been debated by courts and the decision has been described as forbidding Congress to prescribe rules of decision for pending cases without amending the law. Even one decision of this Court, in dicta, so confined *Klein*, stating that the 1992 decision in *Robertson v. Seattle Audubon Society*, 503 U.S. 429, 441 (1992) had modified *Klein* despite that decision's express refusal to do so. *See Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (quoting *Robertson*, 503 U.S. at 441, in part for the proposition the prohibition of *Klein* "does not take hold when Congress 'amends applicable law'");

but see Robertson, 503 U.S. at 441 (stating that the court "need not consider whether this reading of *Klein* is correct" because it disagreed with lower court as to whether the statute at issue had amended applicable law).

Even if *Klein* is to be read merely as *Plaut* described it, Section 4714 is constitutionally flawed. Its retroactive aspect affects only a discrete and readily-identifiable category of cases—those in which health care providers have asserted their rights to payment under the prior law. It sweeps no more broadly. It affects no other payments made, or to be made, for services provided before the effective date. Article III of the Constitution denies Congress the power to enact such a narrowly retroactive statute. *See Plaut*, 514 U.S. at 228; *Klein*, 13 Wall. (80 U.S.) at 146-47. The Seventh Circuit's failure to examine this flaw is doubly inappropriate because the prescribed rule of decision eliminates the United States' obligation to fulfill a bargain previously struck to pay for services already performed. *See United States v. Carlton*, 512 U.S. 26, 39-40 (1994) (Scalia, J., concurring) (legislation "eliminating the specifically promised reward for costly action *after* the action has been taken, and refusing to reimburse the cost" is "harsh and oppressive" beyond bounds of court's substantive due process test) (emphasis in original).

Klein must at least mean that Congress violates the separation of powers doctrine when it alters the outcome of pending cases to benefit the federal government. *Sioux Nation* recognized this point, and the language of *Klein* is clear and has not been disturbed. This case, and others on appeal when Section 4714 was enacted, involved the federal government as a financially interested party. Section 4714 of the BBA violated the core holding of *Klein* by dictating the result for the purpose of saving government money.

Medicaid is a joint federal-state venture.[7] Application of Section 4714 to pending cases saves money for both the state and federal governments. *See* App. 49 (Congressional Budget Office estimates of net *federal* savings from Section 4714 totaling $2.1 billion by 2002 and $5.6 billion by 2007). The federal government contributes at least 50 percent of the money used for the cost sharing payments sought by Petitioners in this and similar cases, *see id.*; 42 U.S.C. § 1396d(b), and cannot credibly deny the necessary financial effect on it from the application of Section 4714 to pending lawsuits. App. 9. (BBA appears to have been "designed to change the original statute in order to reduce the cost of Medicaid to the federal government").

The QMB patients for whom services have been provided are beneficiaries of Medicare, a wholly federal program. The federal government is inextricably involved in the programs at issue, and will benefit financially from the Seventh Circuit's deference to the congressional "clarification."

Retroactive application of any statute is limited by the Constitution. *See Landgraf v. USI Film Products*, 511 U.S. 244, 267 (1994) (citing provisions other than Article III). Basic separation of powers principles require that an exception to the general rule be found here. Were it not so, few, if any, obstacles to congressional interference would exist. Unfettered application of Section 4714 will, as in *Klein*, effectively determine the outcome of particular cases

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[7] *See Michigan Hosp. Ass'n v. Dept. of Social Services*, 738 F.Supp. 1080, 1081 (W.D. Mich. 1990) (describing Medicaid as "a federal-state joint venture"); *see also Wilder v. Virginia Hosp. Ass'n.*, 496 U.S. 498, 502 (1990) (Medicaid is a "cooperative" federal-state program); *Harris*, 448 U.S. at 308 (same); *Bowen v. Massachusetts*, 487 U.S. 879, 883 (1988) (same); *Illinois Health Care Ass'n v. Bradley*, 776 F.Supp. 411, 413 (N.D. Ill. 1991), *aff'd*, 983 F.2d 1460 (CA7 1993) (Medicare is a "joint" federal-state enterprise).

pending against the federal government and resolve them in the government's favor to its significant financial benefit.

The Seventh Circuit, in deferring to the congressional "clarification," ignored separation of powers principles. Certiorari should be granted in light of continuing controversy over the meaning of *Klein*, particularly when applied, as here, to an issue capable of recurring in every cycle of budgetary legislation. *See Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 47-48 (1977).

III. Review is Necessary Because the Retroactive Application of Section 4714 Unconstitutionally Impairs Protected Property Rights.

The Seventh Circuit's opinion did not address the serious Fifth Amendment takings, due process and the Contract Clause issues raised by Congress' effort to eliminate the government's obligation to pay cost sharing under the guise of a "clarification" of prior law, and the State of Illinois' action in reliance on it. Instead of considering the existence of these issues as a factor which might militate against judicial deference to the legislature, the court below felt constrained to give weight to the "clarification" pretext, and thereby side stepped a long and recently-affirmed line of this Court's decisions invalidating efforts by Congress to repudiate the contractual obligations of the United States.

This Court recently reiterated that ordinary contract principles apply to government agreements and that the federal government may not retroactively eliminate its own debts to save money. *See United States v. Winstar Corp.*, 116 S. Ct. at 2459-60 and n. 28, 2464-65 and n. 39, 2468, n. 51 (plurality opinion), 2475-76 (Breyer, J., concurring), 2478-79 (Scalia, J., concurring, joined by two justices); *see*

also Bowen v. Public Agencies Opposed to Social Security Entrapment, 477 U.S. 41, 55 (1986). This Court noted that the most protectable of government contracts with private parties are those in procurement or similar situations. *Id.* at 2457. Here, both the procurement and the rendition of services by contractors (Petitioners) had already been completed under existing law. *Id.* at 2457.

Section 4714 extinguishes obligations due and owing under the prior law. The services here have already been provided, as even Congress recognized. App. 41 (amendments "shall also apply to payment by a State for items and services furnished before" date of enactment if subject of a lawsuit). The law in effect when Petitioners provided services required payment to them at the Medicare rate—including Part B cost sharing from state and federal Medicaid funds. *See Kozlowski*, 42 F.3d at 1459-60; *Haynes*, 36 F.3d at 1076-77; *Snider*, 29 F.3d at 894-95, 903; *Perales*, 954 F.2d at 859-63. Those rights were assigned to Petitioners, in certain cases, as required by 42 U.S.C. § 1395w-4(g)(3)(A). The Petitioners' rights to payment were vested.[8] An implied contract also arises upon services being rendered under a law specifying compensation to be paid at specified rates. *See Mississippi ex rel. Robertson v. Miller*, 276 U.S. 174, 179 (1928).

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[8] Many providers who comprise the plaintiff class provided medical services for QMBs under "participation" agreements which obligated them to accept assignment of a Medicare beneficiary's right to payment, 42 U.S.C. § 1395u(h), and limited them to recovery of 100 percent of the Medicare-approved charge. *See id.* § 1395u(b)(3)(B)(ii). Suppliers of services to QMBs are required to sign participation contracts. *Id.* § 1395w-4(g)(3)(A). The Medicare Part B participation agreement for physicians and suppliers contemplates that they will receive full payment, stating that a doctor "shall not collect from the beneficiary or other person or organization [such as an insurer] more than the applicable deductible and coinsurance." *See* 42 U.S.C. § 1320a-7b(d).

These rights under government contracts are properly protected by both the Due Process and Takings Clauses, as well as the Contract Clause as against state impairment. *See United States Trust Co. v. New Jersey*, 431 U.S. 1, 22, 29 (1977) (Contract Clause); *Thorpe v. Housing Authority*, 393 U.S. 268, 278 n.31 (1969) (due process); *Lynch v. United States*, 292 U.S. 571, 579 (1934) (takings); *Madera Irrig. Dist. v. Hancock*, 985 F.2d 1397, 1401 (CA9 1993) (takings); *Minnesota Assn. of Health Care v. Minn. Dept. of Pub. Welfare*, 742 F.2d 442, 450-51 (CA8 1984) (Contract Clause); *Caritas Services, Inc. v. Dept. of Social & Health Services*, 869 P.2d 28, 41 (Wash. 1994) (Contract Clause); *Oberlander v. Perales*, 740 F.2d 116, 120 (CA2 1984) (due process); *but see Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224 (1986) (leaving extent of protection by Takings Clause undecided).[9]

All four opinions in *Winstar* recognized similar rights as protectable against retroactive abrogation by the sovereign, relying on this Court's long-standing decisions in *Lynch*, 292 U.S. 571, and *Perry v. United States*, 294 U.S. 330 (1935), "the two principal cases of this century holding that the government may not simply repudiate its contractual obligations." *See id.* at 2478 (Scalia, J., concurring, joined by two justices); *see also* 116 S.Ct. at 2455, 2559-60 & n. 28, 2464-65 & n. 39, 2468-69 n. 31 (plurality opinion); *id.* at 2473 (Breyer, J., concurring); *id.* at 2481 (Rehnquist, C.J., dissenting). Both *Lynch* and *Perry* make clear that congressional abrogation of the "essential bargain" of a contract is "impermissible repudiation." *Winstar*, 116 S. Ct. at 2479 (Scalia, J., concurring); *see Perry*, 294 U.S. at 435; *Lynch*, 292 U.S. at 580.

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[9] Actions of state governments in a joint relationship involving federal action may be attributed to the United States for takings purposes. *See Preseault v. United States*, 100 F.3d 1525, 1551 (Fed. Cir. 1996) (en banc).

Here, the United States and the State of Illinois have retroactively eliminated, through Section 4714, contractual rights even more worthy of protection than the prospective insurance benefits at issue in *Lynch*. *See* 292 U.S. at 580-81. Their actions and Section 4714 violate both the takings clause and the due process guarantee of the Fifth Amendment and, (as against Illinois) the Contract Clause. *See Lynch*; *United States Trust Co.*; *Perry*; *cf. United States v. Larionoff*, 431 U.S. 864, 880 (1977) (intimating that Congress may not deprive service member of pay due for duties already performed). The benefit that the United States will derive from retroactive application of Section 4714 cannot be overlooked. "[I]t makes sense to scrutinize governmental action more closely when the State stands to benefit." *Harmelin v. Michigan*, 501 U.S. 957, 978 n.9 (1991) (citing *Perry*, 294 U.S. at 350-51). The United States will save billions by not having to pay matching funds. *See* App. 49.

The Seventh Circuit's failure to address these constitutional concerns elevates deference to a purported congressional clarification above the Petitioners' vested property interests. Certiorari should be granted to re-establish the vitality of the constitutional principles of *Lynch* and *Perry* in these circumstances and to sustain the Petitioners' Contract Clause rights as against the State of Illinois.

IV. Certiorari Should be Granted to Resolve a Conflict Among the Circuits Regarding the States' Obligations to Pay Medicare Cost Sharing on Behalf of QMBs With Respect to Services Rendered Prior to August 5, 1997.

Although fairly implicated by Petitioners' request that this Court provide guidance as to the weight to be given to the retroactive budgetary "clarification" of the QMB payment provisions, it is also important for this Court explicitly to resolve the conflict thus engendered over the correct

interpretation of the QMB provisions as they existed before the Balanced Budget Act.

As described above, the four Circuits held that the plain meaning of 42 U.S.C. § 1396a(a)(10)(E), requiring states to "make available" medical assistance for "medicare cost sharing," combined with the explicit definition of "medicare cost sharing" at 42 U.S.C. § 1396d(p)(3), was clear and did not permit the limitations urged by the states and the Secretary. Consequently, the four Circuits rejected the Secretary's position that 42 U.S.C. § 1396a(n) allowed the states, at their option, to "make available" something less, or even nothing, and thereby to ignore and eviscerate § 1396a(a)(10)(E). The four Circuits collectively analyzed the statutory scheme at length and concluded that the Secretary's position was due no deference under *Chevron* principles. *See Kozlowski*, 42 F.3d at 1446-60; *Snider*, 29 F.3d at 888-903; *Haynes*, 36 F.3d at 1076-77; *Perales*, 954 F.2d at 856-63.

The Seventh and Ninth Circuits, with far less analysis of the statute, found that the original statutes were ambiguous and that the Secretary's interpretation, as "clarified" by Congress, should prevail. Neither court discussed the meaning of 42 U.S.C. §§ 1396a(a)(10)(E) or 1396d(p)(3) in detail, the Ninth Circuit specifically electing to "eschew any analysis" of the statutes without even any citation to them. *See Beverly Comm. Hosp.*, 132 F.3d at 1264.

Although inextricably intertwined with the question of deference to the later enactment, the conflict in the circuits undermines this Court's foundational rules of statutory construction that enactments are to be given their plain meaning and the words of the statute are deemed the best indicators of congressional intent. *See e.g.*, *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-254 (1992); *Richards v. United States*, 369 U.S. 1, 9 (1962). Likewise, the conflicting interpretations distort this Court's teaching that if legislative history must be consulted, it is the intent of the enacting Congress, not the opinions of a subsequent

one, that is controlling. *See Pierce v. Underwood*, 487 U.S. 552, 566-67 (1988); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979). Certiorari should be granted to resolve the conflict among the circuits.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the judgment of the United States Court of Appeals for the Seventh Circuit.

Respectfully submitted,

Bruce S. Sperling
Counsel of Record
Sperling, Slater & Spitz
Suite 3300
55 West Monroe Street
Chicago, IL 60603
(312) 641-3200

Judith S. Sherwin
Mark J. Bereyso
Levenfeld, Eisenberg, Janger
& Glassberg
21st Floor
33 West Monroe Street
Chicago, IL 60603
(312) 346-8380

Harvey J. Barnett
Harvey J. Barnett & Associates, P.C.
Suite 2220
200 West Adams Street
Chicago, IL 60606
(312) 407-7300

Counsel for Petitioner,
Paramount Health Systems, Inc.

Steven A. Kaufman
Peter K. Levitt
Ropes & Gray
One International Place
Boston, MA 02110-2624
(617) 951-7000

Daniel P. Hogan
Ross & Hardies
150 North Michigan Avenue
Suite 2500
Chicago, IL 60601
(312) 750-8671

Counsel for Petitioner,
Metropolitan Ambulance Association

Of Counsel:

Robert W. McCann
James A. Barker, Jr.
Green, Stewart, Farber Anderson, P.C.
Suite 1111
2600 Virginia Avenue, N.W.
Washington, D.C. 20037
(202) 342-8700

APPENDIX

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Nos. 96-3457 & 96-3458

PARAMOUNT HEALTH SYSTEMS, INC., personally and on behalf of all persons similarly situated,

Plaintiffs-Appellees,

v.

ROBERT W. WRIGHT, Director, Illinois Department of Public Aid, and DONNA E. SHALALA, Secretary of Health and Human Services,

Defendants-Appellants.

Appeals from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 95 C 1620—**Robert W. Gettleman,** *Judge.*

ARGUED APRIL 17, 1997—REARGUED JANUARY 15, 1998
DECIDED MARCH 19, 1998

Before POSNER, *Chief Judge,* and COFFEY and RIPPLE, *Circuit Judges.*

POSNER, *Chief Judge.* The question we were asked to decide when this case was first appealed by Health and Human Services and its Illinois counterpart was whether, as both appellants (collectively, "the government") contend, federal law permits the state to reimburse providers of medical care to a class of Medicare beneficiaries known

as "qualified Medicare beneficiaries" ("QMBs," pronounced "quimbies," and we shall use the phonetic spelling to spare the reader an acronym) at Medicaid rates rather than at Medicare rates. The district judge in this class action on behalf of such providers (a term that we are using in its colloquial sense rather than in its technical Medicare senses, see, e.g., 42 U.S.C. §§ 1395x(u), 1395cc(e)) held, in agreement with decisions of the four other circuits in which the issue had arisen, that federal law indeed required reimbursement at the higher, Medicare rates. See *Rehabilitation Association of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994); *Haynes Ambulance Service, Inc. v. Alabama*, 36 F.3d 1074 (11th Cir. 1994) (per curiam); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886 (3d Cir. 1994); *New York City Health & Hospitals Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992). The judge issued an injunction commanding the government to reimburse the members of the class at those rates, but he stayed the injunction pending this appeal. As a result of subsequent legislation that led us to order supplemental briefing and reargument, it is no longer clear whether, even if the district judge's decision was correct when made, it is correct today. But it will simplify discussion to examine his ruling first under the law at the time.

The state makes a pair of threshold arguments not joined by the federal government, which was included as a defendant only, so far as we can determine, because it approved the provision of the state's Medicaid plan that denies reimbursement to providers of services for quimbies at Medicare rates. The first argument is that Paramount, the class representative, lacks standing to sue in federal court because it is not a direct provider of services to quimbies. Instead it sells these services to nursing homes which in turn provide them to its quimby residents. The state argues that Paramount should seek reimbursement from the nursing homes, its customers, rather than from the state. Paramount replies that the nursing home is a mere con-

duit, which unless it receives reimbursement of 100 percent of a given expense will not reimburse Paramount in full. This is not clear from the record. But no matter. The state's argument is premised on the state's view of the merits. The state *assumes* that quimbies are Medicaid patients; and under the state's Medicaid plan Paramount is required to bill the nursing homes directly. But Paramount claims that quimbies are Part B Medicare patients, and services to such patients are billed not to the patient's nursing home but to a Medicare fiscal intermediary for the 80 percent of the bill that Part B pays, and, in the case of quimbies, to the state for the remaining 20 percent. The state is arguing the merits in the guise of challenging the plaintiff's standing.

The state's second argument on standing is that Paramount has no right to sue it (formally, its officials) to enforce the Medicaid Act. And it is true that the Act does not give providers in Paramount's position an express right to sue state officials. But the providers can, as they have done, sue them under 42 U.S.C. § 1983 if they are within the class intended to be benefited by the Medicaid Act. *Blessing v. Freestone*, 117 S. Ct. 1353, 1359 (1997); *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 508-09 (1990); *Marie O. v. Edgar*, 131 F.3d 610, 618-19 (7th Cir. 1997). On Paramount's interpretation, the Act's provisions concerning quimbies require the states to use their Medicaid funds to reimburse providers at Medicare rates. This makes the providers intended beneficiaries of those provisions, and therefore enables them to sue under section 1983. *Rehabilitation Association of Virginia, Inc. v. Kozlowski, supra*, 42 F.3d at 1449-50; cf. *Wilder v. Virginia Hospital Association, supra*, 496 U.S. at 510.

So we can turn to the merits.

Quimbies are elderly or disabled persons who qualify for Medicare and who, in addition, either qualify by reason of their poverty for Medicaid as well, in which event they are called "dual eligibles," or, though not poor enough to

qualify for Medicaid, cannot easily afford to pay the Medicare Part B premiums, deductible, and copayments; these quimbies are called "pure quimbies." 42 U.S.C. § 1396d (p)(1). Part A of the Medicare program, which covers hospital services, is not at issue in this suit. Part B covers non-hospital services. Persons who decide to enroll in it must pay monthly premiums and also swallow the first $100 of their medical bills for certain of the services covered by Part B; that is the deductible we mentioned. Most important is Part B's copayment provision. Medicare Part B pays only 80 percent of the approved charge for services reimbursed under it, so that the participant must, to the extent that his medical expenses are not covered by private insurance, dig into his own pocket to pay the balance.

Quimbies, however, are excused from the premium, deductible, and copayment provisions. The state bears these costs because federal law makes state participation in the Medicaid program, for which the federal government picks up a minimum of half the tab, conditional on the state's agreeing to defray those Medicare costs of quimbies that the federal government does not reimburse, 42 U.S.C. §§ 1396a(a)(10)(E)(i), 1396d(p)(3), even though "pure" quimbies are not even eligible for Medicaid. The 20 percent copayment is at the heart of this suit. The law is perfectly clear that the states if they want to be part of Medicaid (as all but one do) must pay the Part B premiums, the deductible, and the 20 percent copayment (the other 80 percent being paid by the federal government, just as with other Medicare participants). But the law is not perfectly clear about what cost figure to use in figuring the copayment, and with what consequence. (Remember that we are speaking of the law as it stood when the district judge issued the injunction.)

The government argues that even under that law it is the Medicaid, not the Medicare, cost that should be used. The Medicare ceilings are almost always higher. This can make a big difference to the providers' entitlements and the gov-

ernment's expense. Suppose that for the same service the Medicare-approved rate is $100 and the Medicaid-approved rate only $70. Paramount claims that when it renders the service to a quimby, it is entitled to be reimbursed $80 by the federal government (which is conceded) and (what is contested) $20 by the state (of which the actual cost to the state would be at most $10, since the federal government pays at least half). Otherwise Paramount will be rendering for only $80 a service to a Medicare beneficiary for which Medicare entitles it to $100. The government counters that the proper payment is $70, the Medicaid rate, and that since Health and Human Services is reimbursing the provider $80, the state need give the provider nothing; the provider is already being overpaid, since $80 is larger than $70.

The government's argument implies that in facilitating the access of quimbies to Part B of Medicare at the (partial) expense of the states, Congress was reducing the reimbursement of providers of Medicare services to this class of Medicare beneficiaries, with the result that Medicare providers would receive different compensation ($100 versus $80, in our example) for rendering the identical services to different Medicare beneficiaries. Congress may have wanted to do this, but the indications are scanty. The category of "dual eligibles" goes back to the original Medicaid and Medicare statutes of 1965, and, as pointed out in the *Rehabilitation Association* case, at first states were not required to pick up the full 20 percent copayment tab. 42 F.3d at 1451-52; *id.* at 1467 (dissenting opinion). But the Medicaid Act defines "medicare cost-sharing" to include Medicare Part B premiums, the $100 deductible, and the 20 percent Medicare copayment. 42 U.S.C. § 1396d(p)(3). And it requires the states participating in Medicaid to "mak[e] medical assistance [i.e., Medicaid funds] available for medicare cost-sharing" as thus defined. 42 U.S.C. § 1396a (a)(10)(E)(i). The natural inference from requiring the state to share (to the extent of Part B premiums and deductible

plus 20 percent of the medical expense) the *Medicare* cost of a class of *Medicare* beneficiaries is that it is indeed the Medicare, not the Medicaid, cost that the state is being asked to bear.

The government points us, however, to a section of the Medicaid Act which provides that in the case of the 20 percent copayment, the state's Medicaid plan "*may* provide payment [to providers, for services to quimbies] in an amount . . . exceeding the amount that is otherwise payable under the State plan . . . for eligible individuals [i.e., eligible for Medicaid] who are not" quimbies. 42 U.S.C. § 1396a(n) (emphasis added). The government argues that this language makes the state's duty of reimbursement at Medicare rates optional, and if this is right, then since section 1396a(a)(10)(E)(i) appears to make such reimbursement mandatory, the Act as a whole (so far as bears on the issue of cost-sharing for quimbies) is ambiguous, thus bringing into play the *Chevron* doctrine of deference to agency interpretations of vague or incomplete statutes. *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984); see, e.g., *Hanson v. Espy*, 8 F.3d 469, 474-77 (7th Cir. 1993); *Watkins v. Blinzinger*, 789 F.2d 474, 478 (7th Cir. 1986); *Gunn v. U.S. Dept. of Agriculture*, 118 F.3d 1233, 1238 (8th Cir. 1997).

Granted, an alternative possibility is that the permissive language is just intended to avoid an ambiguity that would be created by the Medicare cost-sharing language if the statute did not explicitly authorize the state to exceed the Medicaid cost level. The statute elsewhere forbids the state under dire penalties to reimburse providers in excess of prescribed levels, 42 U.S.C. § 1396c, lest the states squander funds provided to them by the federal government. See 42 U.S.C. § 1396b(a)(1); see also *Pennsylvania Medical Society v. Snider, supra*, 29 F.3d at 895. The language of section 1396a(n) makes clear that the ceiling can be pierced without penalty if necessary to enable the state to comply with the requirement that it reimburse the provid-

ers of services to quimbies at Medicare rates—which is why the provision excludes premiums, since they are not reimbursements to providers.

But this interpretation is undermined by the fact that if, as Paramount must and does argue, the statute *clearly* entitles it to reimbursement at Medicare rates (if it is not clear, *Chevron* is back in play), the state could hardly be penalized for such reimbursement. That would be penalizing it for complying with the statute. What is more, section 1396a(n) dates only from 1986. Providers of services for dual eligibles had for more than twenty years—since the original enactment of the Medicaid and Medicare statutes—been receiving reimbursement at higher than Medicaid rates not only without penalty but also without anyone, so far as we are aware, raising the spectre of possible penalties.

Another problem with Paramount's interpretation is that even after the enactment of section 1396a(n) in 1986, states were for a time still not required to reimburse dual eligibles at full Medicare rates. This was because of a provision, 42 U.S.C. § 1396a(a)(15), that was not made applicable to the new (the pure) quimbies, who instead were placed under section 1396a(a)(10)(E), the section we quoted earlier that appears to require full Medicare cost-sharing, and section 1396a(n). If these two sections are read as Paramount desires and thus require full Medicare cost-sharing for pure quimbies, it means that in 1986 Congress decided that the states must be more generous to pure quimbies than to dual eligibles, even though pure quimbies are the more affluent quimbies. Remember that dual eligibles are persons who because of their poverty qualify for Medicaid as well as Medicare, while pure quimbies are not poor enough to qualify for Medicaid.

Is all this enough to render the statute ambiguous and thus bring the *Chevron* doctrine into play despite the contrary view of the four circuits to have addressed the issue?

Before trying to answer this question, we should consider the bearing of the Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251, which was not available to those courts. Section 4714(a) of the Act provides that a state is not required to reimburse providers of services to quimbies at Medicare rates, and subsection (c) makes the provision in (a) applicable both to services rendered after the date of enactment and to services rendered before enactment if payment for those services was an issue in a suit pending on that date, as this suit was. Clearly the Act extinguishes any right the plaintiffs might have to be reimbursed at the Medicare rates for services they provide to quimbies after the date of enactment; the question is whether it also extinguishes their right to services they provided before.

The answer is clearly "yes" if, as the Ninth Circuit concluded in *Beverly Community Hospital Ass'n v. Belshe*, 132 F.3d 1259 (9th Cir. 1997), section 4714(a) merely clarifies, and by clarifying confirms the government's version of, the original meaning of the quimby reimbursement provisions. There is an air of unreality in treating section 4714(a) as an attempted clarification of original statutory meaning, although it is captioned "Clarification Regarding State Liability for Medicare Cost-Sharing." The disputed quimby provisions date from 1986 (see Pub. L. No. 99-509, § 9403, 100 Stat. 1874, 2053-56)—eleven years before the Balanced Budget Act was passed. The membership of Congress had largely turned over during the interim and surely few members of the 105th Congress who had been members of Congress back in 1986 remembered what the membership's intentions had been regarding the esoteric issue of the reimbursement rate for providers of medical services to quimbies. In any event, Congress is not an interpretive body and has no felt duty to maintain continuity with the past. "The views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49 (1963); see also *South Dakota v. Yankton Sioux*

Tribe, 118 S. Ct. 789, 803-04 (1998). The location of the 1997 amendments in a statute labeled the "Balanced Budget Act" and concerned primarily with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the 1997 quimby provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government. Nothing in the provisions themselves suggests a process of interpretation; they merely declare that the states are not required to reimburse quimby providers at the Medicare rate.

Yet we have been instructed that subsequent legislation "declaring the intent of an earlier statute is entitled to great weight in statutory construction." *Loving v. United States*, 116 S. Ct. 1737, 1749 (1996); *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 118 n. 13 (1980); *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 (1969); *Brown v. Marquette Savings & Loan Ass'n*, 686 F.2d 608, 615 (7th Cir. 1982). This precept is not easy to reconcile with the language we quoted from *Philadelphia National Bank*—language quoted approvingly by the Supreme Court just months ago in the *Yankton* case. Or with the principle that Congress cannot direct the outcome of a pending case without changing the law applicable to that case. E.g., *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995); *Robertson v. Seattle Audubon Society*, 503 U.S. 429, 441 (1992); *United States v. Klein*, 80 U.S. (13 Wall.) 128, 146-47 (1872); *United States v. Papia*, 910 F.2d 1357, 1362-63 (7th Cir. 1990); *Benjamin v. Jacobson*, 124 F.3d 162, 173-74 (2d Cir. 1997). Otherwise a disappointed litigant in a statutory case in a federal district court could scurry to Congress while the case was on appeal and request a "clarifying" amendment that would reverse the interpretation that the district judge had given to the statute, even if that meaning was crystal clear and even though a statute depriving a litigant of a judgment that he had won and that had become final after exhaustion of appellate remedies would be

an unconstitutional taking unless the litigant received just compensation. *Central States, Southeast & Southwest Areas Pension Fund v. Lady Baltimore Foods, Inc.*, 960 F.2d 1339, 1345-46 (7th Cir. 1992); *Tonya K. v. Board of Education*, 847 F.2d 1243, 1247-48 (7th Cir. 1988); *Axel Johnson Inc. v. Arthur Andersen & Co.*, 6 F.3d 78, 83-84 (2d Cir. 1993). There was no final judgment here and so no taking under the "vested rights" line of cases just cited. But the principle that Congress can't direct a judgment in a pending case is based not on the takings clause of the Fifth Amendment but on Article III, which vests the judicial power of the United States in the judicial rather than the legislative branch. See *Central States, Southeast & Southwest Areas Pension Fund v. Lady Baltimore Foods, Inc., supra*, 960 F.2d at 1345; *Axel Johnson Inc. v. Arthur Andersen & Co., supra*, 6 F.3d at 83-84.

It is tempting to try to reconcile the *Loving* line and the *Philadelphia Bank* line by saying that the difference is that the first involves actual legislation and the second mere legislative materials, committee reports and the like ("legislative history"—a curious term to use of legislators' statements made *after* the legislation sought to be interpreted had been enacted). This will work for some of the cases, such as *GTE Sylvania, Philadelphia National Bank*, and *United States v. United Mine Workers*, 330 U.S. 258, 281-82 (1947), in the *Philadelphia Bank* line, and *Loving* and *Red Lion* in the *Loving* line. But *Yankton*, along with *Rainwater v. United States*, 356 U.S. 590, 593 (1958), gives little weight to subsequent legislation as a guide to interpreting an earlier Congress's intent. And *Yankton* is the Supreme Court's latest word on the subject.

So we're in a quandary concerning the continued vitality of the *Loving* line, and would welcome clarification from the Supreme Court—pending which we feel constrained by *Loving* to give *some* weight to Congress's declaration in the Balanced Budget Act that providers of services to quimbies are not entitled to reimbursement at full Medicare

rates. Although we don't how much weight to give it—probably rather little in the circumstances—it is enough to tip the balance in favor of *Chevron* deference. The Act is a hopeless muddle so far as quimby reimbursement is concerned, and while it seems to us that Paramount has the better interpretation, there is sufficient ambiguity to require us to defer to the government. The judgment of the district court must therefore be reversed.

There is, however, a subordinate issue still to be discussed. Paramount argued, and the district court held, that Paramount is entitled to be reimbursed for the services it provides for quimbies in nursing homes from the state directly, rather than from the nursing homes. Because it is unclear whether the issue is independent of the main issue and survives our resolution of it, we shall remand the case and ask the district court to reconsider its ruling on the subordinate issue.

REVERSED AND REMANDED.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

JUDGMENT - WITH ORAL ARGUMENT

Date: March 19, 1998

BEFORE: Honorable RICHARD A. POSNER, Chief Judge
Honorable JOHN L. COFFEY, Circuit Judge
Honorable KENNETH F. RIPPLE, Circuit Judge

Nos. 96-3457 & 96-3458

PARAMOUNT HEALTH SYSTEMS, INCORPORATED and METROPOLITAN AMBULANCE ASSOCIATION,

Plaintiffs - Appellees

v.

ROBERT W. WRIGHT, Director, Illinois Department of Public Aid, and DONNA E. SHALALA, Secretary of Health and Human Services,

Defendants - Appellants

Appeals from the United States District Court
for the Northern District of Illinois, Eastern Division
No. 95 C 1620, Robert W. Gettleman, Judge

The judgment of the District Court is REVERSED, with costs, and this cause is REMANDED, in accordance with the decision of this court entered on this date.

[Entered July 25, 1996]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

PARAMOUNT HEALTH SYSTEMS, INC., Plaintiff, and METROPOLITAN AMBULANCE ASSOCIATION, et al., Intervenor Plaintiff, v. ROBERT W. WRIGHT, Director, Illinois Department of Public Aid, and DONNA E. SHALALA, Secretary United States Department of Health and Human Services, Defendants.	)	No. 95 C 1620 Judge Robert W. Gettleman

MEMORANDUM OPINION AND ORDER

Plaintiff Paramount Health Systems, Inc. ("Paramount") has brought this putative class action against defendants Robert W. Wright ("Wright"), Director of the Illinois Department of Public Aid ("IDPA"), and Donna Shalala, Secretary of the United States Department of Health and Human Services (the "Secretary"), challenging the legality of certain aspects of Illinois's medical assistance program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.* (the

"Medicaid Act"). The Metropolitan Ambulance Association (the "MAA") has moved for and received leave to intervene as a plaintiff. Plaintiffs essentially allege that the Illinois medical assistance program, as approved by the Secretary and administered by Wright, violates Title XVIII of the Social Security Act, 42 U.S.C. § 1395, *et seq.* (the "Medicare Act") as well as the Medicaid Act. Plaintiff Paramount has moved for summary judgment, the MAA has filed a brief in support of that motion, Wright has responded to the motion, and the Secretary has filed a cross-motion for summary judgment. For the reasons set forth below, plaintiff's motion for summary judgment is granted, and the Secretary's cross-motion for summary judgment is denied.

DISCUSSION[1]

Paramount furnishes enteral-feeding supplies to, among others, QMBs in Illinois. Wright, as Director of IDPA, administers the Illinois medical assistance program that was established pursuant to the Medicaid Act. The Secretary administers the Medicaid and Medicare Acts, and is responsible for reviewing state plans for medical assistance and approving those plans that comply with the requirements of Medicare and Medicaid.

Paramount argues that as a Medicare Part B provider it is entitled to receive 100% of the lesser of the pro-

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[1] A brief discussion of the Medicare Act, the Medicaid Act and, in particular, the provisions relating to Qualified Medicare beneficiaries ("QMBs") can be found in the court's previous opinion in this case, *Paramount Health Systems, Inc. v. Wright,* 907 F. Supp. 1212 (N.D. Ill. 1995).

vider's customary charge or the reasonable costs and charges as determined by the Secretary. 42 U.S.C. §§ 13951, 1395CC(a)(2)(A). The federal government (through Medicare) pays 80% of those reasonable charges. For QMB's, the state is responsible for the remaining 20% copayment. The main issue in this case is whether the state can reduce or eliminate its portion of the payment by subjecting it to its Medicaid rate limits.

IDPA pays providers of enteral-feeding supplies (including Paramount) to QMBs not residing in nursing facilities the full Medicare Part B rate. If the QMB resides in a nursing facility, however, IDPA does not reimburse the providers directly. Rather, under the Illinois medical assistance plan, the nursing home is considered the provider of the equipment to Medicaid recipients, and nursing facilities are reimbursed the costs incurred in providing feeding equipment to Medicaid recipients according to IDPA's nursing facility rate. Feeding equipment, under the State Medicaid plan, is classified as a supply cost for reimbursement purposes. Supply costs are "bundled" together with other costs and paid on a per diem basis subject to IDPA's nursing facility rate. The IDPA provider handbook mandates that payments for durable medical equipment such as the feeding supplies at issue be made directly to the nursing facilities which, in turn, pay providers such as Paramount. Such providers are required to enter into "provider agreements" with IDPA which require the providers to seek payment from the nursing facilities. Therefore, defendant Wright has asserted, and continues to assert, that Paramount has contracted away any claim for payment greater than that provided by the Medicaid rate.

In contrast to Paramount, the MAA, which is an association of private for-profit entities engaged in the business of providing fee for service ambulance transportation, provides its services directly to QMBs rather than through nursing homes. Therefore, it is undisputed that the MAA members are direct Medicare Part B providers; they bill and receive payment directly from the federal government (except for the state's co-payment) and any contract-related arguments presented by Wright are inapplicable to them.

Despite Wright's attempts to argue otherwise[2], this court agrees with the Secretary's assessment that the issue presented by this case is one of statutory interpretation. More particularly, the court is faced with the issue of whether the Medicare and Medicaid Acts permit states to choose to limit payment of the Medicare Part B deductibles and 0% co-payment due for QMBs to the amount by which the Medicaid rate for the same goods or services provided exceeds what Medicare Part B has paid.

This issue has been decided in the negative by all four circuit courts of appeal that have addressed it. *Pennsylvania Medical Society v. Snider*, 29 F.3d 886 (3rd Cir. 1994); *Rehabilitation Association of Virginia Inc. v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994); *Haynes Ambulance Service, Inc. v. Alabama*, 36 F.3d 1074 (8th Cir. 1994);

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[2] The court rejects the state's argument that a derivative suit pending in state court against Paramount somehow creates an issue of fact as to Paramount's ability to maintain the instant action. Even if the state court orders Paramount's dissolution, it would still have the authority and ability to bring this action. 805 ILCS 5/12.80.

and *New York City Health and Hospitals Corp. v. Perales,* 954 F.2d 854 (2nd Cir. 1992). This court has reviewed those circuit court decisions, as well as the dissents in several of those cases and the underlying district court opinions, and agrees with the majority circuit court opinions that the Medicare and Medicaid Acts clearly and unequivocally require states to pay the entire amount of Part B cost sharing on behalf of all QMBs. In particular, the court agrees with the reasoning and result reached by the Third Circuit in *Snider* that QMB payments are part of Medicare and not Medicaid,[3] and that Medicare provides for payment to providers of 100% of their reasonable charges. *See also Kozlowski*, 42 F.3d at 1459 ("We thus join both of the other circuits that have passed on this question in holding that there can be no doubt but that the QMB is a Medicare enrollee and that payment on her behalf must be made at the Medicare rate.").

Deciding that QMBs are Medicare enrollees and that payments on their behalf must be made at the Medicare rate resolves the issue as to the MAA. With respect to Paramount, however, the issue is a little more complicated. A little, but not much. Wright argues that because IDPA contracts with nursing facilities to care for residents covered by the Illinois medical assistance program, the nursing facilities have a contractual responsibility to provide the feeding supplies at issue (which the

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[3] In addition to the reasoning of the circuit courts that have concluded that QMB payments are covered by Medicare rather than Medicaid, this court notes that the "M" in QMB stands for Medicare. Clearly, QMBs are Medicare enrollees, and providers of services to them are entitled to 100% of their reasonable damages.

state plan lumps with other equipment and supplies as "durable medical equipment" ("DME")) to its residents. According to the IDPA provider handbook, the State reimburses the nursing facilities directly for all such DME, regardless of whether the equipment is provided to a QMB or a pure Medicaid recipient. The State has thus unilaterally designated the nursing facilities as the providers of equipment to the QMB. It then bundles those costs with other nursing costs and pays them on a per diem rate. It is undisputed that this method results in a payment to the nursing facility that is less than the reasonable charge for the equipment as set by the federal government under the Medicare rate. IDPA requires providers such as Paramount to enter agreements with it pursuant to which those providers agree to seek reimbursement for Medicare co-payments from the nursing facility. The State argues, therefore, that Paramount has contracted away any claim for payment above the Medicare rate, which is always less than the amount paid by the federal government.

There are numerous problems with this argument. First, it seeks to do indirectly to Paramount what this court has already determined it cannot do directly to the MAA. It applies the State Medicaid payment scheme to supplies provided under Medicare. By defining the nursing facility as the QMB "provider" it has forced Paramount to accept less than full payment at the Medicare rate. It has done so, however, by treating all providers to nursing facilities as "Medicaid" providers, without regard to whether the supplies are actually provided to QMBs. Because this court has already determined that providers to QMBs are entitled to 100% of the reasonable charges as set by the federal government, not by

the State's Medicaid rate, the payment scheme is invalid.

Additionally, even under the State's contractual setup, it is still required to pay 100% of the reasonable charge for services and supplies to QMB's as set by the federal government to the nursing home, which the State has defined as the QMB provider. Those funds should then filter through to providers such as Paramount, ensuring that the actual provider receives 100% of the reasonable cost. Thus, even if the state were allowed to require indirect payment to the actual provider (which it is not), it still cannot apply its Medicaid rate to the payment. It Oust pay the provider 100% of the reasonable charges.

Moreover, the court does not accept the State's designation of the nursing facility as the "provider." As noted in *Kozlowski*, 42 F.3d at 1460:

> "Just because one is required to see that service is provided does not make one the provider of the service. While the long-term care facility is required to provide certain service under the Medicaid Act, it is not, in fact, the provider of the services in question. . . . While the nursing facility may be required to provide the service under the Medicaid Act, in this instance it contracts with these third parties who provide the service."

Accordingly, the court concludes that the Illinois scheme denies Paramount its right to full and direct reimbursement of Medicare Part B cost-sharing for items and services rendered to Illinois QMBs.

Finally, the Secretary has argued that because the four circuit courts have reached the same result by differing reasoning, this court should conclude that the statutory schemes in question are ambiguous as to the

question before the court, and that reasonable minds may differ on the precise interpretation. Therefore, according to the Secretary, her interpretation should be given deference under *Chevron U.S.A. v. National Resources Defense Council*, 467 U.S. 837 (1986).

The problem with the Secretary's argument is twofold. Before *Chevron* applies, the court must determine that the statutory scheme is ambiguous. Once that is determined, the court must give deference to the Secretary's interpretation only if that interpretation is reasonable. *Smiley v. City Bank (South Dakota) N.A.*, 116 S. Ct. 1730, 1735 (1996).

The Secretary argues that because the four circuit courts have applied different reasoning to reach their results, the statutory scheme must be deemed ambiguous. The court disagrees. Although applying slightly different reasoning, it was abundantly clear to all four circuit courts that have reached the issue that the Medicare Act requires that QMB providers be reimbursed 100% of their reasonable charges, and that the states cannot curtail that right. Rather than being discordant in their reasoning, the courts of appeal understandably developed their rationales interpreting these lengthy and confusing statutes based upon the successive opinions on the subject. This court has reached the same conclusion, and although the statutes are difficult to parse, they are not ambiguous. Moreover, even if this court were to determine that the statutes in question are ambiguous, it could not, and would not, determine that the Secretary's interpretation is reasonable. The simple fact is that the plain wording of the statute provides that QMB providers are to receive 100% of their reasonable costs, and that the state is required to pay

the QMBs' 20% share of those costs. Therefore, the court concludes that *Chevron* is inapplicable to the instant case.

CONCLUSION

For the reasons set forth above, plaintiff's motion for summary judgment is granted, and the Secretary's cross-motion for summary judgment is denied. Plaintiff is directed to prepare a final judgment order for declaratory and injunctive relief consistent with this opinion.

ENTER: July 25, 1996

/s/ Robert W. Gettleman
Robert W. Gettleman
United States District Judge

[Entered August 2, 1996]

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

PARAMOUNT HEALTH SYSTEMS, INC., Plaintiff, and METROPOLITAN AMBULANCE ASS'N, et al., Intervenors, v. ROBERT W. WRIGHT, Director, Illinois Department of Public Aid, and DONNA E. SHALALA, Secretary, United States Department of Health and Human Services, Defendants.	No. 95 C 1620 Hon. Robert W. Gettleman

FINAL JUDGMENT

Pursuant to this Court's Memorandum Opinion and Order entered July 25, 1996, final judgment for declaratory, injunction, and other relief is hereby ordered and entered as set forth below. This final judgment is entered on behalf of, and for the benefit of plaintiff, Paramount Health Systems, Inc., and the class it represents, which includes the members of the intervenor, Metropolitan Ambulance Association, and against the defendants, Robert W. Wright, Director, Illinois Department of Pub-

lic Aid ("IDPA") and Donna Shalala, Secretary, United States Department of Health and Human Services.

IT IS HEREBY DECLARED AND ORDERED:

1. The Medicare and Medicaid Acts, 42 U.S.C. § 1395, *et seq.* ("Medicare"), and 42 U.S.C. § 1396, *et seq.* ("Medicaid"), clearly and unequivocally require the states, including the state of Illinois, to directly pay the full and complete Medicare cost-sharing amounts for Medicare Part B items and services furnished to Qualified Medicare Beneficiaries ("QMBs"), as defined under federal law at 42 U.S.C. § 1396d(p)(1). The cost-sharing amounts include all amounts set forth in 42 U.S.C. § 1396d(p)(3).

2. To the extent a state statutory or regulatory scheme purports to preclude, deny, or limit full and direct reimbursement of Medicare Part B cost sharing to the entities and individuals who furnish such items and services to QMBs, such state payment scheme is invalid and unenforceable. The Illinois Medicaid Plan, and the regulations and contracts which interpret and apply the state's cost-sharing obligation as set forth above, are invalid and unenforceable, to the extent that they:

a. Limit such cost-sharing reimbursement to amounts or rates set by the state of Illinois, so that the amount of reimbursement paid is less than the full amount of Medicare cost-sharing as set forth in paragraph 1 above (89 Ill. Adm. Code § 140.21(b));

b. Require persons and entities who furnish items or services covered by Medicare Part B to enter into "provider agreements" with IDPA which, in turn, require such persons and entities to seek payment or reimbursement for such items or services not

directly from the IDPA, but indirectly from third parties, including a nursing home in which the QMB resides (89 Ill. Adm. Code S 140.21(a)), or otherwise restrict the right of direct and full reimbursement or payment of cost-sharing to persons and entities who furnish Part B items and services to QMBs;

c. Otherwise limit the amount of such cost-sharing reimbursement for Medicare Part B items or services furnished to QMBs residing in nursing homes, as addressed in sub-paragraph (a) above (89 Ill. Adm. Code § 140.21).

3. It is the legal duty of defendant Wright, as Director of the Illinois Department of Public Aid, to comply with the law hereby declared. Defendant Wright and his successors, officers, agents, employees, and servants are hereby ordered to make full and direct payment of all Medicare Part B cost-sharing amounts, at the Medicare-allowed rate or amount, to entities and persons who furnish such items and services to QMBs. This injunction applies to the payment of all claims for items and services furnished to Illinois QMBs after the date of entry of this judgment. Furthermore, defendant Wright, and his successors, officers, agents, and servants are permanently enjoined from implementing or enforcing any rule, regulation, policy or practice which would restrict or deny full, complete, and direct reimbursement of Medicare Part B cost-sharing amounts to persons and entities who furnish Medicare Part B items and services to QMBs for items and services furnished to Illinois QMBs after the date of entry of this judgment.

4. It is the legal duty of defendant Donna Shalala, as Secretary, United States Department of Health and

Human Services, to comply with the law as hereby declared. Defendant Shalala, her successors, officers, agents, employees, and servants are hereby ordered not to approve or facilitate any Illinois state law, plan, regulation or policy that would preclude, deny or limit full and direct reimbursement of Medicare Part B cost-sharing to the persons and entities who furnish such items and services to QMBs, and any such policy or regulation promulgated by the Secretary is invalid and unenforceable. In particular, the Secretary's approval of that portion of the state of Illinois' Medicaid plan, limiting cost-sharing to state plan rates, is invalid and unenforceable.

CLASS CERTIFICATION

5. This action shall be maintained as a class action under Fed. R. Civ. P. 23. The prerequisites of Rule 23(a) are satisfied, and in addition "the part[ies] opposing the class have acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief . . . with respect to the class as a whole." Fed. R. Civ. P. 23(b)(2).

a. The class is defined as all entities and persons who have furnished items or services or will furnish items or services covered by Medicare Part B since March 1, 1993 to Illinois QMBs.

b. Plaintiff Paramount Health Systems, Inc. is an entity which has furnished health care items and services to Illinois QMBs since March 1, 1993, including items and services covered by Medicare Part B, has suffered injury to its business and property by reason of the policies and practices of the defen-

dants as addressed herein, and has been and is a fair and adequate representative to present and protect the interests of the class.

c. Counsel for Paramount, Bruce S. Sperling, Mark J. Bereyso, and Judith S. Sherwin, are capable of fairly and adequately representing the interests of the class.

d. The members of intervenor, Metropolitan Ambulance Association, are entities which have furnished ambulance services to Illinois QMBs since at least March 1, 1993, including items and services covered by Medicare Part B, and which have suffered injury to their businesses and property by reason of the policies and practices of the defendants as addressed herein.

COMPLIANCE

6. Defendant Wright, as Director of IDPA, his successors, officers, agents, employees and servants are further ordered:

a. To provide class counsel with reasonable information regarding the steps the IDPA has taken and will take to implement the provisions of this final judgment and to provide class counsel with such other information as the court may require. Without limiting the foregoing, defendant Wright, as Director of IDPA, his successors, officers, agents, employees and servants shall maintain adequate and readily accessible records of each claim or request for payment that is subject to this final judgment which is not paid directly and in full by the IDPA while the

stay entered below remains in effect, so that those claims and requests for payment may be promptly paid in the event the stay referred to below is dissolved or lifted, or this final judgment is affirmed on appeal.

b. To provide notice of this final judgment to members of the class within 60 days of entry hereof, by including a one page, double-sided copy of this judgment, at least once, in any regular business mailing to class members, and by causing a notice of this class action and this final judgment to be published in a manner and to the extent agreed by class counsel, or otherwise as approved by this Court. Such published notice shall, at a minimum, advise class members of the substance of this final judgment and provide information to allow class members to contact class counsel for the purpose of obtaining further information concerning the status of the action.

FEES AND COSTS

7. Plaintiffs are the prevailing party. Therefore, plaintiffs' fees and costs may be assessed pursuant to, *inter alia*, 42 U.S.C. § 1988 and/or 28 U.S.C. § 2412. Class counsel are also entitled to be awarded fees and costs by reason of having successfully obtained relief for the class. The Court retains jurisdiction to determine these issues. Petitions for fees and costs shall be filed within 30 days of the entry of this final judgment.

STAY

8. Enforcement of this final judgment is stayed pending timely appeal to the United States Court of Appeals for the Seventh Circuit. The state of Illinois shall maintain adequate and readily accessible records of each claim or request for payment subject to this final judgment which is not paid directly and fully pending such appeal. Such records shall be in a form to allow for prompt payment in the event the stay is dissolved or lifted or this final judgment is affirmed on appeal.

ENTER: August 2, 1996

/s/ Robert W. Gettleman
Robert W. Gettleman
United States District Judge

CONSTITUTIONAL PROVISIONS

U.S. Const., art. I, § 10 (first paragraph)

No State shall enter into any Treaty, Alliance, or Confederation; grant letters of Marque and Reprisal; coin Money; emit Bills of Credit; make any Thing but gold and silver Coin a Tender in Payment of Debts; pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility.

U.S. Const., art. III, § 1. Judicial Power, Tenure and Compensation

The judicial Power of the United States, shall be vested in one Supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

U.S. Const., amend. V.

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATUTES

Amendments enacted pursuant to § 4714 of the Balanced Budget Act of 1997 are set forth in [bracketed] italics.

42 U.S.C. § 1395*l* Payment of benefits

(a) Amounts

Except as provided in section 1395mm of this title and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of an individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k (a)(1) of this title 80 percent of the reasonable charges for the services; except that . . . (N) with respect to expenses incurred for physicians' services (as defined in section 1395w4 (j)(3) of this title, the amounts paid shall be 80 percent of the payment basis determined under section 1395w4(a)(1) of this title, . . .

42 U.S.C. § 1395m. Special payment rules for particular items and services

(a) Payment for durable medical equipment

(1) General rule for payment

(A) In general

With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the fre-

quency specified in paragraphs (2) though (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

42 U.S.C. §1395u. Use of carriers for administration of benefits

(h) Participating physician or supplier; agreement with Secretary; publication of directories; availability; inclusion of program in explanation of benefits; payment of claims on an assignment related basis

(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year. . . .

42 U.S.C. §1395w-4. Payment for physicians' services

(a) Payment based on fee schedule

(1) In general

Effective for all physicians' services (as defined in subsection (j)(3) of this section) furnished under this part

during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m(b) of this title, payment under this part instead shall be based on the lesser of

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) of this section for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(g) Limitation on beneficiary liability

(3) Limitation on charges for medicare beneficiaries eligible for medicaid benefits

(A) In general

Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicate beneficiary, as defined in section 1396d(p)(1) of this title) with respect to such services under a State plan approved under subchapter XIX of this chapter may only be made on an assignment-related basis [*and the provisions of section 1396a(n)(3)(A) apply to further limit permissible charges under this section*].

42 U.S.C. § 1395 cc. Agreements with providers of services

(a) Filing of agreements; eligibility for payment; charges with respect to items and services

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1), (a)(3), or (a)(4), section 1395*l*(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 percentum of the amount customarily charged for such items and services by such provider) for which payment is made under Part B of this subchapter or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary.

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A state plan for medical assistance must—

(10) provide—

(E)(i) for making medical assistance available for medicare cost sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title; . . . except that . . . (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and 13960(b) of this title,

(n) Payment amounts

[*(1)*] In the case of medical assistance furnished under this subchapter for medicare cost sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

[*(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or co-payments far medicare cost-sharing to the extent that payment under subchapter XVIII for services would exceed the payment amount that otherwise would be made under the State plan under this subchapter for*

such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)

(A) for purposes of applying any limitation under subchapter XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396a(m)(1)(A) for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.]

42 U.S.C. § 1396b. Payment to States

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amounts determined under subsection (a)(1)

of this section for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 and over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII of this chapter, other than amounts expended under provisions of the plan of such State required by section 1396a(a) (34) of this title.

42 U.S.C. § 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provisions; the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396d. Definitions

For purposes of this subchapter—

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to section 1396u-3 of this title, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum. . . .

(p) Qualified medicate beneficiary; medicare cost sharing

(1) The term "qualified medicate beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2 of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program except as provided in paragraph (2) (D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382a of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

(3) The term "medicare cost sharing" means [*(subject to section 1396a(n)(2) of this title)*] the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items or services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i-2 or 1395i2a of this title, and

(ii) premiums under section 1395r of this title,

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395*l*(b) of this title).

(D) The difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of the State, premiums for enrollment of a qualified medicate beneficiary with an eligible organization under section 1395mm of this title.

105th Congress
1st Session

Report
105-217

HOUSE OF REPRESENTATIVES

BALANCED BUDGET ACT OF 1997

CONFERENCE REPORT
TO ACCOMPANY
H.R. 2015

* * * *

TITLE IV—MEDICARE, MEDICAID, AND CHILDREN HEALTH PROGRAMS

Subtitle H Medicaid

Chapter 2—Flexibility In Payment of Providers

SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING.

(a) CLARIFICATION REGARDING STATE LABILITY FOR MEDICARE COST-SHARING.

(1) IN GENERAL—Section 1902(n) (42 U.S.C. 1396a(n)) is amended—

(A) by inserting "(1)" after "(a)", and

(B) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if

provided to an eligible recipient other than a medicare beneficiary.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

"(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

"(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

"(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.".

(2) CONFORMING CLARIFICATION.—Section 1905 (p)(3) (42 U.S.C. 1396d(p)3)) is amended by inserting "(subject to section 1902(n)(2))" after "means".

(b) LIMITATION ON MEDICARE PROVIDERS.

(1) PROVIDER AGREEMENTS.—Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the comma at the end the following: ", and (ii) not to impose any charge that is prohibited under section 1902(n)(3)".

(2) NONPARTICIPATING PROVIDERS.—Section 1848(g)(3)(A) (42 U.S.C. 1395w4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902 (n)(3)(A) apply to further limit permissible charges under this section".

(C) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

* * * *

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2015) to provide for reconciliation pursuant to sections 104 to 105 of the concurrent resolution on the budget for fiscal year 1997, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

* * * *

MEDICAL PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING

Section 5712 of Senate amendment

CURRENT LAW

State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligibles) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of required payment has been the subject of some controversy.

State Medicaid programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charges only to

the extent that the Medicare provider has not received the full Medicaid rate for an item or service. Some courts have forced state Medicaid programs to reimburse Medicare providers to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals.

HOUSE BILL

No provision.

SENATE AMENDMENT

Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state's Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally, provides that any sanctions for excess charges that may be imposed on a provider or managed care entity under Medicare may be imposed for making excess charges under Medicaid.

Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

REGULATIONS

42 C.F.R § 400.202 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

. . .

Payment on an assignment-related basis means payment for Part B services—

(1) To a physician or other supplier that accepts assignment from the beneficiary, in accordance with § 424.55 or § 424.56 of this chapter;

(4) For services furnished by a person or entity other then those specified in paragraphs (b)(l) through (b)(3) of this section, 80 percent of the reasonable charges or 80 percent of the amount computed on any other payment basis for the services.

42 C.F.R. § 424.55 Payment to the supplier.

(a) Medicare pays the supplier for covered services if the beneficiary (or the person authorized to request payment on the beneficiary's behalf) assigns the claim to the supplier and the supplier accepts assignment.

(b) In accepting assignment, the supplier agrees to the following:

(1) To accept, as the full charge for the service, the amount the carrier determines to be the reasonable charge.

(2) To limit charges to the beneficiary as follows:

(i) To collect nothing for those services for which Medicare pays 100 percent of the reasonable charge.

(ii) To collect only the Mount of the unmet deductible, plus 20 percent of the difference between the reasonable charge and the unmet deductible for those services for which Medicare pays 80 percent of that difference.

Illinois Administrative Code, title 89

Section 140.21 Covered Medicaid Service for Qualified Medicare Beneficiaries (QMBs)

a) In order to be qualified to receive reimbursement for services provided to QMB eligible clients (see 89 Ill. Adm. Code 120.72), providers must be enrolled in the Medicaid Program. Providers must also accept assignment of Medicare benefits for QMB recipients, when payment for services to such persons is sought from the Department.

b) For Medicaid covered services, the Department will reimburse qualified providers who render services to QMBs in accordance with Department standards for the service(s) provided. For non-Medicaid covered services, the Department will reimburse qualified providers who render services to QMBs at the full Medicare deductible and coinsurance rate.

(Source: Added at 12 Ill. Reg. 14391, effective August 31, 1989)

June E. O'Neill
Director

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
Washington, D.C. 20515

August 12, 1997

Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

The Congressional Budget Office, after consulting with the Committees on the Budget of the House of Representatives and the Senate, provides the enclosed estimates of the effects of H.R. 2014 (Public Law 105-34), the Taxpayer Relief Act of 1997, and H.R. 2015 (Public Law 105-33), the Balanced Budget Act of 1997, on direct spending and receipts. These estimates are required by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 2014 and H.R. 2015 were cleared by the Congress on July 31 and signed by the President on August 5. Section 10213 of H.R. 2015 provides that these two laws are not counted for pay-as-you-go purposes.

On August 11 the President identified one provision of Public Law 105-33 and two provisions of Public Law 105-34 for cancellation under the terms of the Line Item Veto Act. CBO's estimates do not reflect the effects of the proposed cancellations.

Sincerely,

/s/ June E. O'Neill
June E. O'Neill

Enclosures

cc: Honorable John R. Kasich
Chairman, House Committee on the Budget

Honorable John M. Spratt, Jr.
Ranking Minority Member; House Committee on the Budget

Honorable Pete V. Domenici
Chairman, Senate Committee on the Budget

Honorable Frank R. Lautenberg
Ranking Minority Member, Senate Committee on the Budget

Honorable Bill Archer
Chairman, House Committee on Ways and Means

Honorable Charles B. Rangel
Ranking Minority Member, House Committee on Ways and Means

Honorable William V. Roth, Jr.
Chairman, Senate Committee on Finance

Honorable Daniel Patrick Moynihan
Ranking Minority Member, Senate Committee on Finance

BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997

SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budget by 2002, the 105th Congress enacted and President Clinton signed two major pieces of legislation: the Taxpayer Relief Act of 1997 (H.R. 2014/Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 10533). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- $112 billion from slowing the growth of the Medicare program;
- $21 billion from auctioning licenses to use portions of the electromagnetic spectrum;
- $7 billion from changes to Medicaid;
- $5 billion from increasing excise taxes on cigarettes and other tobacco products; and
- $15 billion from other spending reductions and tax increases.

These savings are partly offset by additional spending of $33 billion:

- $20 billion for children's health insurance initiatives and
- $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but these provisions do not directly alter federal outlays or revenues. The summary table provides estimates of the act's budgetary effects by title. The following pages give details by program and provision.

Table 4D. — Estimated Budgetary Impact of Subtitle H. Medicaid

(By fiscal year, in billions of dollars)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002 Total	1998-2007 Total
Medicaid rates for Medicare cost sharing for QMB and dually eligible beneficiaries												
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.6
Medicare Benefits	0.6	0.6	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3

SOURCE: Congressional Budget Office

* * *

Medicaid Rates as Payment in Full. In recent years, many states have been required by court decisions to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns these decisions and gives states the option not to pay providers Medicare cost sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payment rates are on average about 73 percent of Medicare payment rates. Limiting payment rates to providers for QMBs and dual eligibles to the lower payment rates will generate about $5 billion in federal Medicaid savings. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

* * *